

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40577

State File No. _____

5322

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|--|--|--|--|---|--|--|--|
| BIRTH NO. _____ | | REG. DIST. NO. <u>149</u> | | PRIMARY REG. DIST. NO. <u>1002</u> | | Registrar's No. _____ | |
| 1. PLACE OF DEATH a. COUNTY <u>Jackson</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u> | | c. LENGTH OF STAY (in this place) <u>52 yrs</u> | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u> | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1543 Denver</u> | | | | d. STREET ADDRESS (If rural, give location) <u>1543 Denver</u> | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Adelia</u> | | b. (Middle) <u>Flynn</u> | | c. (Last) <u>Beets</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 19, 1950</u> | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> | | 8. DATE OF BIRTH <u>March 13, 1861</u> | |
| 9. AGE (in years last birthday) <u>89</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | | 11. BIRTHPLACE (State or foreign country) <u>Minn.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13a. FATHER'S NAME <u>John Flynn</u> | | 13b. MOTHER'S MAIDEN NAME <u>Unknown</u> | | 14. NAME OF HUSBAND OR WIFE <u>James W. Beets</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Frank J. Flynn 1543 Denver K.C., MO.</u> | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Arteriosclerosis, Smoked</u> DUE TO (c) <u>Smoking</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 mo</u> <u>3317</u> | |
| 19a. DATE OF OPERATION _____ | | 19b. MAJOR FINDINGS OF OPERATION _____ | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____ | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____ | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) _____ | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? _____ | | | |
| 22. I hereby certify that I attended the deceased from <u>Oct 16, 1950</u> , to <u>Dec 14, 1950</u> , that I last saw the deceased alive on <u>Dec 14, 1950</u> , and that death occurred at _____ m., from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE <u>Ralph Perry M.D.</u> (Degree or title) | | | | 23b. ADDRESS <u>4800 East 24</u> | | 23c. DATE SIGNED <u>Dec 14/1950</u> | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24b. DATE <u>12/21/50</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Washington Cem.</u> | | 24d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u> | |
| DATE REC'D BY LOCAL REG. <u>12-19-50</u> | | REGISTRAR'S SIGNATURE <u>S. L. Holmes</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Earp & Sons Funeral Home</u> | | ADDRESS <u>K.C., Mo.</u> | |

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

working under my personal supervision.

Signed.....
Student Embalmer

Signed

Student Embalmer No.....

Licensed Embalmer No.

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.